SUPPLEMENT TO THE STATE OF INDIANA HEALTH EXHIBIT

For the Year Ending December 31, 2006

Pursuant to Indiana Code 27-8-10-2.1, net losses of the Indiana Comprehensive Health Insurance Association shall be assessed to its members in accordance with the methodology set forth in Indiana Code, as amended. Indiana Code 27-8-10-2.1(e)(2) gives the Association the authority to take any legal actions necessary to collect assessments from members. You are required to complete the following Supplement Form and return it to the address listed below by March 1, 2007, even if your company has nothing to report for the calendar year indicated.

Company Information:

NAIC #: _____

Company Name: _____

Company Address: _____

_____

Contact Name: _____ Phone: _____

Billing Address (if different from above): _____

_____

Billing Contact: _____ Phone: _____

Indiana Premium Deductions

INSTRUCTIONS:

Report the premium amounts from the following types/sources included in written premiums reported in the below referenced locations from your company's annual statement for Indiana only. The allowable deductions are those types of premium excluded from accident and sickness insurance per Indiana Code 27-8-5-2.5(a), plus premium from Federal government sources.

PREMIUM INFORMATION:

ICHIA will obtain written premium information from the Indiana Department of Insurance rather than from member companies. Your premium information will be taken from the following location in the company's annual statement. **A copy of this page from your company's annual statement must be returned with this Supplement Form.**

Life Companies:	Page 25, Column 1, Line 26
P&C Companies:	Page 20, Column 1, Lines 13, 14, & 15
Health (HMOs & LSHMOs) Companies	Page 30, Column 1, Line 12

Company Name: _____ NAIC #: _____

PREMIUM DEDUCTIONS:
Since premium information will be obtained from the IDOI, please report deductions only.

(1)	Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.	$_____ (A)
(2)	Coverage issued as a supplement to liability insurance.	$_____ (B)
(3)	Automobile medical payment insurance.	$_____ (C)
(4)	A specified disease policy issued as an individual policy.	$_____ (D)
(5)	A limited benefit health insurance policy issued as an individual policy.	$_____ (E)
(6)	A short term insurance plan that (a) may not be renewed and (b) has a duration of not more than six (6) months.	$_____ (F)
(7)	A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.	$_____ (G)
(8)	Worker's compensation or similar insurance.	$_____ (H)
(9)	A student health insurance policy.	$_____ (I)
(10)	Medicaid, Medicare Risk and FEHBP.	$_____ (J)

Total Deductions [Sum of (A) through (J)] **$**_____

Signature of Officer
I affirm, under penalties of perjury, the above figures are true and correct according to the best of my information, knowledge, and belief. I understand that the above named company will be held responsible for errors in the above figures.

Signature of Officer: _____ Date: _____

Printed Name of Officer: _____

Title of Officer: _____

Mailing Address and Preparation Questions

The supplement must be returned via traceable mail (UPS, Fedex, Certified Mail, etc.). Please be sure to include your Indiana State Page referenced above.

ICHIA
Attn: Client Accounting
4550 Victory Lane
PO Box 33730
Indianapolis, IN 46203

Phone: (317) 614-2018
Fax: (317) 614-2011